SECTION 1: INMATE INFORMATION (PRINT LEGIBLY)

NAME	CDC NUMBER	DOB
CURRENT HOUSING/PLACEMENT		AS OF

SECTION 2: MEDICAL INFORMATION (PRINT LEGIBLY)

DIAGNOSIS
PROGNOSIS
CURRENT MEDICAL/PHYSICAL CONDITION (LIST ABILITIES AND LIMITATIONS FOR EACH ACTIVITY)
MENTAL STATUS
BREATHING
EATING
BATHING
DRESSING
TRANSFERRING
ELIMINATION
ARM USE
AMBULATION

SECTION 3: TO BE COMPLETED ONLY IF MEDICAL PAROLE REQUESTED BY INMATE'S FAMILY MEMBER OR DESIGNEE (PRINT LEGIBLY)

REQUESTOR'S NAME:	DATE OF REQUEST:
RELATIONSHIP TO INMATE :	

SECTION 4: CONSENT FOR RELEASE OF MEDICAL INFORMATION

CHECK ONE OF THE FOLLOWING:	
☐	CONSENT GIVEN BY INMATE OR INMATE'S AUTHORIZED REPRESENTATIVE. CDCR FORM 7385 ATTACHED.
☐	INMATE UNABLE TO CONSENT AND DOES NOT HAVE AN AUTHORIZED REPRESENTATIVE TO CONSENT ON HIS/HER BEHALF. CONSENT FOR RELEASE OF MEDICAL INFORMATION HAS BEEN REQUESTED THROUGH THE COURT.

PRINT OR TYPE CPHCS PRIMARY CARE PHYSICIAN'S NAME	CPHCS PRIMARY CARE PHYSICIAN'S SIGNATURE	DATE/TIME

INMATE'S NAME	CDC NUMBER

SECTION 5: ELIGIBILITY APPROVALS (PRINT LEGIBLY)

FOR INSTITUTION CHIEF MEDICAL OFFICER (CMO)/CHIEF MEDICAL EXECUTIVE (CME) COMPLETION:

MEDICALLY ELIGIBLE? ☐ YES ☐ NO	COMMENTS:	
PRINT OR TYPE CMO/CME NAME	CMO/CME SIGNATURE	DATE

FOR CLASSIFICATION AND PAROLE REPRESENTATIVE (C&PR) COMPLETION:

STATUTORILY ELIGIBLE? ☐ YES ☐ NO	IF NO, CHECK REASON: ☐ LWOP ☐ CONDEMNED

IF INMATE IS STATUTORILY ELIGIBLE, ATTACH THE FOLLOWING DOCUMENTS TO THIS FORM AND RETURN TO CHIEF MEDICAL OFFICER/CHIEF MEDICAL EXECUTIVE:

☐ COUNTY OF LAST LEGAL RESIDENCE:

☐ AOJ	☐ POR	☐ LSS	☐ ISRS	☐ MOST RECENT 128-G W/ INMATE'S CASE FACTORS	☐ CII NUMBER

☐ VICTIM NOTIFICATION(S) ON FILE (IF YES, CHECK BOX)

PRINT OR TYPE C&PR NAME	C&PR SIGNATURE	DATE

SECTION 6: PLACEMENT PLAN APPROVALS (PRINT LEGIBLY)

FOR CALIFORNIA PRISON HEALTH CARE SERVICES (CPHCS) COMPLETION:

PLACEMENT PLAN ACCEPTED BY

FACILITY NAME	TELEPHONE NUMBER

FACILITY ADDRESS

FACILITY CONTACT NAME AND TITLE

PRINT OR TYPE CPHCS REPRESENTATIVE NAME	CPHCS REPRESENTATIVE SIGNATURE	DATE

FOR DIVISION OF ADULT PAROLE OPERATIONS (DAPO) COMPLETION:

PLACEMENT PLAN APPROVED? ☐ YES ☐ NO	COMMENTS:

SEE ATTACHED CDCR FORM 1515-MP, CONDITIONS OF MEDICAL PAROLE, FOR ANY RESTRICTIONS: ☐

PAROLE AGENT NAME (PRINT NAME OR TYPE):	PAROLE AGENT SIGNATURE	BADGE #	
PAROLE UNIT:		TELEPHONE NUMBER:	
PAROLE UNIT SUPERVISOR (PRINT NAME OR TYPE)	PAROLE UNIT SUPERVISOR SIGNATURE	BADGE #	DATE

For CPHCS Internal Use Only:

FUNDING/BENEFIT SOURCE	REQUEST APPROVED ☐ YES ☐ NO	DATE APPROVED:

PRINT OR TYPE CPHCS REPRESENTATIVE NAME	CPHCS REPRESENTATIVE SIGNATURE	DATE